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MISSOURI DENTAL BOARD
3605 MISSOURI BOULEVARD
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JEFFERSON CITY, MO 65102-1367
TELEPHONE (573) 751-0040
FAX (573) 751-8216
TTY (800) 735-2966

STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION

PATIENT INJURY OR DEATH REPORTING

INSTRUCTIONS

- This form must be typed or printed legibly in **black** ink.
- Pursuant to 20 CSR 2110-2.210, a dentist who practices in this state shall submit a report to the board within thirty (30) days of any mortality or any injury requiring medical attention and/or treatment from a licensed healthcare provider which occurs to a patient during treatment or within twenty-four (24) hours of receiving treatment from the dentist that resulted in mortality or injury.
- Additional sheets may be used to provide a more detailed explanation.

* **Please attach a copy of the patient's records.**

SECTION I - LICENSEE DATA

NAME (FIRST, MIDDLE, LAST, SUFFIX, FORMER/MAIDEN)		MISSOURI LICENSE NO.
HOME TELEPHONE NUMBER	BUSINESS TELEPHONE NUMBER	FAX NUMBER
MAILING ADDRESS: STREET ADDRESS (IF PO BOX, PLEASE ALSO PROVIDE A STREET ADDRESS.)		
CITY	STATE	ZIP

TYPE OF PRACTICE

☐ Specialty Practice in the Area of _____

☐ General Practice

DO YOU HAVE A DEEP SEDATION/GENERAL ANESTHESIA PERMIT?
☐ Yes ☐ No

DO YOU HAVE A PARENTERAL MODERATE SEDATION PERMIT?
☐ Yes ☐ No

DO YOU HAVE AN ENTERAL MODERATE SEDATION PERMIT?
☐ Yes ☐ No

SECTION II - PATIENT DATA

NAME (FIRST, MIDDLE, LAST, SUFFIX)	DATE OF BIRTH	DATE OF INJURY OR DEATH	
ADDRESS (IF PO BOX, PLEASE ALSO PROVIDE A STREET ADDRESS.)	CITY	STATE	ZIP
NAME OF CLOSEST RELATIVE, IF KNOWN			
MEDICAL HISTORY OF PATIENT			
HISTORY OF PATIENT WITH YOUR OFFICE			
DESCRIPTION OF PRE-OPERATIVE PHYSICAL CONDITION OF PATIENT			

DESCRIPTION OF DENTAL PROCEDURES/EVENTS LEADING TO INJURY OR DEATH

LIST OF DRUGS, DOSAGE AND ROUTE OF ADMINISTRATION GIVEN TO PATIENT

DESCRIPTION OF ADVERSE OCCURRENCE, INCLUDING ONSET AND TYPE OF SIGNS AND SYMPTOMS, TREATMENT INSTITUTED AND RESPONSE TO TREATMENT

WAS AN AMBULANCE CALLED? ☐ YES ☐ NO IF YES, NAME AND ADDRESS OF AMBULANCE

WAS PATIENT TAKEN TO HOSPITAL? ☐ YES ☐ NO IF YES, NAME AND ADDRESS OF HOSPITAL

IF AN INJURY, DESCRIPTION OF THE PATIENT'S PRESENT CONDITION FOLLOWING MEDICAL INTERVENTION

IF PATIENT WAS PRONOUNCED DEAD, WHERE AND BY WHOM

WAS AN AUTOPSY PERFORMED ☐ YES ☐ NO IF YES, WHERE AND BY WHOM?

SECTION III - LICENSEE SIGNATURE

I declare that all statements or representations contained in or attached to this report are made under oath or affirmation and are true and correct to my best knowledge under penalty of section 575.060 RSMo which specifies that anyone who makes a false statement in writing with intent to mislead a public official in the performance of his official duties is guilty of a class B misdemeanor.

SIGNATURE OF LICENSEE	DATE